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Detection & Treatment of Depression among Older Adults

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Myths of Mental Illness

- Mental illness is incurable
- Depression is a natural consequence of aging
- Preoccupation with death is typical of older adults
- Treatment of depression in older adults is ineffective
Prevalence in Older Adults

- Rates for older adults in community settings meeting the full (5) criteria for depression probably slightly less than in young adults.
- Rates for dysthymic disorder (chronic minor depression where only 2 criteria are met) are slightly more in older adults.
- Overall findings suggest that rates of depression for community dwelling older adults are similar to those of community dwelling younger adults.
Prevalence of depression

• Most common late onset problem, and one of the most common late life problems

• Rates of depression in older adults are much higher in hospital, assisted living facility and nursing home settings than they are in community settings
Consequences of Late Life Depression

- Excess disability
- Functional decline
- Increased health service utilization
- Medical morbidity & mortality
- Reduced quality of life
- Caregiver burden – ½ of spouses depressed
- Suicide
Causes of Depression

- Genetics – inherited vulnerability
- Biological – changes in brain chemicals (decreases in norepinephrine, serotonin?) (but “chemical imbalance” theory has never been proven)
- Psychosocial – accumulation of losses – more typical of late onset depression
Common Losses of Aging

- Deaths of spouses, relatives, friends
- Retirement
- Parenting Role
- Health & Functioning
- Independence
- Prestige
Depression, Grief & Mourning

- Grief – personal emotional reaction to a loss
- Mourning – public display of grief
- Complicated Grief (CG) – Different from depression?
- DSM-5 allows labeling CG as MDD if depressive symptoms occur for 1 month after 6-month bereavement
- Persistent complex bereavement disorder (DSM-5)
  - Preoccupation with thoughts of the deceased & circumstances of death, intense suffering, social identity disruption > 12 months after the loss {Proposed for further study in DSM-5}
  - May need grief + PTSD work
Symptoms of Depression

- Persistent sad, anxious, or “empty mood”
- Feelings of hopelessness, pessimism
- Loss of interest or pleasure in activities
- Sleep disturbance (too much / too little)
- Crying spells
Symptoms of Depression (cont)

- Eating disturbance (too much / too little)
- Decreased energy, fatigue, ennui
- Suicidal thoughts, gestures, attempts – white males over 75 have highest suicide rate
Symptoms Particularly Prominent in Older Adults

- Difficulty with concentration, making decisions
- Vague physical symptoms or chronic pain not responsive to treatment
- Memory complaints
- Anxiety
- Irritability
- Depletion syndrome – withdrawal, apathy, less energy
- However, less sadness, guilt, admission of suicidality
Rules of Thumb to Distinguish Depression from Dementia

- Depressed older adults are more likely to have prior depressive episodes
- Self-reported memory problems are more common among depressed patients
- With depression, more typically a sudden onset of ‘memory’ problems
Rules of Thumb (cont)

- Depressed people show affective changes along with cognitive changes.
- Errors on mental status exams variable & motivational.
- ‘Pseudodementia’ = Acute global cognitive changes - biochemical concomitants of depression.
- Depressed focus on disabilities; PWDs make light of memory problems.
Involutional Melancholia

- Gradual onset age 40-55 (women) 50-65 (men):
- Anxiety & agitation & restlessness
- Somatic concern & Hypochondriasis
- Guilt ridden
- Occasional somatic or nihilistic delusions
- Insomnia
- Anorexia & weight loss
Depression comorbid with dementia

- Depression & dementia frequently co-exist
- Depression exacerbates memory problems
- Late onset depression is a risk factor for development of dementia – perhaps due to executive/vascular involvement
Depression in Severe Dementia

- Resistance to care
- Lack of participation in care
- Refusal to eat
- Lethargy
- Increasing dependency
- Social withdrawal
Depression in Dementia (cont)

- Rapid deterioration in functioning
- Agitation, catastrophic reactions
- Delusions (e.g., about being poisoned)
- MDS has an item assessing depression
- Depression is now considered an indicator of QOL
Bio-psycho-social Intervention – Medical Approaches

- Physical – thorough exam should R/O physical causes of depression (med side-effects, lung cancer)
- Biological – SSRI anti-depressants (Zoloft, Prozac) more benign side-effect profile than Tricyclics (Elavil) – less cardiotoxic
- ECT – effective, but used as last resort – high relapse rates
Social Treatment

- Depression & social isolation are associated in older adults – older white males living alone without religious affiliation are highest risk for suicide
- Referral to Sr. Ctrs, volunteer organizations, church groups - replace losses, increase social support, feel productive again
Psychotherapy

- Helps older adults accept & replace losses
- Confronts myth that aged person cannot change
CBT

Evidence-based treatment for depression in older adults

Teaches ways of changing negativistic, over-generalized thinking patterns e.g., being unable to do what you used to be able to do doesn’t mean that you are a complete failure as a person

Gallagher-Thompson’s work indicates that CBT may need to be supplemented by interpersonal therapy if older adult has a personality disorder
CBT Modifications

- Some older adults less familiar with psychotherapy – need to be educated about what it's about before they accept it
- Need to adapt to sensory impairments such as vision or auditory problems e.g., use bigger print for homework assignment
- Older adults process information slower – need to simplify instructions, go slower, repeat, make sure person understands,
- Materials can be modified for those with cognitive impairment
Interpersonal Therapy

- IPT is effective in treatment of depressed adults & preventing recurrences
- Appears well suited to deal with the interpersonal losses of older adults:
  - Grief/loss
  - Role transitions
  - Interpersonal conflict
  - Poor social skills
Group & Family Therapy

- **Group** – Allows older individuals to discuss common aging issues; offers peer support
- **Life review** - Evaluative reminiscence gains perspective on the past & affirmation from others – ‘probably efficacious treatment for depression’ – usually conducted in groups
- **Family** – Addresses chronic or late life marital stressors; estrangement from adult children; grandparenting strains
Grief Therapy

- Controversial area
- Debate over whether all bereaved should be offered grief therapy – treatment should never be mandated
- Many older adults are resilient and manage fine on their own with time
- Challenge will be to identify those who are most at risk for development of complicated grief
Final Points

- Each older person deserves an individualized assessment & treatment
- Many need combined approaches i.e., those depressed with PDs may need CBT + interpersonal therapy + meds
- Health professionals should aggressively assess depression in older adults just as with young adults